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ABSTRACT

The paper describes the physical and psychological symptoms of anorexia nervosa, treatment methods, and implications for the classroom. A rationale is offered for the predominance of upper-middle and upper class female adolescents in the anorectic population. Four models of treatment for the anorectic individual are considered: medical, psychodynamic, behavioral, and systems. The two predominant sub-types of anorexia nervosa (bulimic and restrictive) are explained; and characteristics of the "normal" family system versus the anorectic family system are considered. Hospitalization as a treatment is mentioned. Pointed out are flaws in existing research. Among the suggestions offered to teachers for dealing with anorectic students are: to provide a classroom environment that is consistent and clear in structure; to support students' individual needs and realistic abilities; and to act on student behaviors in an objective and appropriate manner. Tables listing characteristics of bulimic and restrictive anorectic patients, compiled from studies done in clinics and in psychiatric hospitals, are included. (SW)

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Anorexia Nervosa- A Teacher's Perspective

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This paper will attempt to briefly describe the physical and psychological symptoms of anorexia nervosa; the varied historical and current therapies used to treat the anorectic child (and family); the two predominant sub-types of anorexia nervosa; the characteristics of the 'normal family' system v.s. the anorectic family system; the hospitilization of the child and the subsequent treatment that follows; the defficiencies in research strategies; and the implications of this illness in the classroom.

I am a special education teacher presently employed by the Toronto Board of Education. It is my belief that it is my responsibility to comprehend, as completely as possible, the nature of the student that I am teaching. During the past seven years I have taught emotionally disturbed adolescents in various treatment settings, yet the anorectic seems to stand out from the 'crowd'. Therefore, through the writing of this paper, I feel that I will have a greater understanding of the complexities of this illness.

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Anorexia Nervosa-A Psychosomatic Disorder

Literally speaking, the term anorexia indicates a 'loss of appetite'; however this is not a true meaning of the illness. Also, it has been thought of as a disorder of eating. Garfinkel(1982), states that in a precise sense that this is

incorrect. The unending pursuit for thinness is secondary to the real need for control and a real sense of mastery over her own body.

Anorexia nervosa is a psychosomatic disorder. The adolescent in her own mind, decides that in order to become more autonomous, she must create this extreme inner conflict between mind and body. As Garfinkel(1982) points out, this is not an attempt at self destruction, but a declaration of self control.

The starvation process that occurs, produces further psychological symptoms. This therefore perpetuates the disorder's continuous cycle.

Minuchin(1978) reported that the mortality rates of 10-15 percent in the disorder are common. Demographically, the syndrome appears in middle class females, while the incidence of male anorectics are very low.

Let me briefly describe a possible rationale why there may be an overrepresentation of upper-middle and upper class female adolescents in the anorectic population. The first question that we can address ourselves to, is, why the adolescent? As the 'normal' child grows and matures, certain physical and emotional changes occur. The child tends to be more secretive of their personal experiences, more responsible for their actions, and thereby becoming an autonomous individual. The physical growth rate of the child is usually not compatible with the emotional growth rate of the child. Adapting to these changes is a difficult process for any person. When we consider the anorectic child, we see certain patterns that could strain the child's normal development into adolescence. (Bruch.1979;

Minuchin,1978)The parents of the anorectic child are usually overprotective, and overinvolved with their child's personal life. According to Bruch. at the time of birth of the anorectic child, the average age of the mother and the father were 32 and 38, respectively. By the time the child reaches adolescence, the parents are also reaching a new period in their lives. The father is approaching or has surpassed his fiftieth birthday, while the mother is in her mid forties. Their own sense of mortality is quite different from that of their adolescent child. This heightened and often exaggerated concern, may encourage the parent to overprotect and stifle their child's development, thereby reinforcing their child's emotional maturation.

One added dimension is the adolescence hypersensitivity to body image and his/her need to get positive reinforcement from their peer group. The advertising industry in North America heightens this anxiety; for example, models are tall and very slender. The adolescent then tries to emulate the model by becoming "thin and beautiful". One's wish to lose weight is exaggerated in the anorexic child to an unhealthy degree.

The second question, could be why is there a disproportionate amount of anorectics in the upper-middle and upper classes? There appears to be a common strand in these two socioeconomic groups. Bruch(1979) stated that financial achievement and social position within the community had a very high priority to the anorectic family. This could possibly answer part of the reason why the anorectic adolescent is such a high achiever in school. Also, the lower-middle and lower class anorectic families have similiar aspirations for themselves. Although these parents may not have

been professional and/or university graduates, they do promote the philosophy of being financially successful, and upwardly mobile. This general life concept 'may' be unique to the latter socioeconomic groups, thereby determining the unequal distribution.

Finally, why more females than males? Without meaning to be a sexist, females tend to develop differently than males. Generally speaking, females mature physically sooner than males. This requires the female to adapt their emotional maturity to this new physical maturity. sooner than they may be ready. The slower physical maturation of the male population provides the males with an opportunity to adjust over a longer period of time, therefore the impact of adolescence is less accentuated for the male population. Secondly, females tend to develop their self-esteem from relationships that they have with friends and family members. Traditionally, males have achieved their self-esteem from specific deeds and accomplishments. Females, in the past, were encouraged to be more passive and less competitive. This tends to support the occurence of anorexia in females. Bruch(1979) stated that the majority of mothers of anorexic daughters gave up their careers when they had their children. They were only recently able to admit their upset feelings about their actions. The mothers were submissive toward their spouse, while truly not repecting them. The role model that the mother provides is one who is not autonomous as a mother, wife, or person. The child is then conflicted as she is in search of a role model that does not exist. If she chooses to seperate from the mother then she does so at great risk as she has

transcended her mother's potential.

Many of the physical symptoms of anorexia nervosa are a direct result of starvation. The physical symptoms may include, (depending on the seriousness of the illness), the following conditions: amenorrhea; cachexia; dehydration; bradycardia; bradypnea; hyperactivity; hypothermia(Minuchin,1978); sleep disturbance; loss of sexual interest(Garfinkel,1982); loss of some hair from the scalp; brittle nails and dry-cracking skin; cyanosis may extend to the nose and ears; a variety of dental problems due to repeated vomiting of long duration (Hurst, Lacey and Crisp,1977); and finally peripheral edema.

The psychological symptoms may include the following: the drive for thinness, fear of gaining weight, denial of hunger, distorted body image(Coleman,1980; Minuchin,1978), inability to accurately identify internal sensations such as satiety or affective states (Bruch.1961,1962.1973,1978), sense of helplessness or ineffectiveness, loss of all interest in sex and encounters with the opposite sex, and a strong desire for control.

With respect to school; the anorectic adolescent exhibits specific characteristics that stand apart from the symptoms previously mentioned. Many 'restrict' all of their attention on activities that are related to the extreme. Specifically, highly active forms of exercise for long durations of time; preparing homework endlessly; and dieting, while all other responsibilities take a tertiary role. Their high grades are usually the result of overachievement(Bruch.1973). High achievement expectations are specific to pleasing others rather than pleasing oneself.

A Historical Perspective

In order to fully understand the complexities of anorexia nervosa, one must examine the evolution of the disorder. Minuchin(1978) describes the evolution as an examination of two conceptual models. The first, the linear model, encompasses the following three therapeutic approaches: the medical, the psychodynamic and finally, the behavioural model. The linear model focuses its therapy predominately on the individual. The second, the systems model, is an extension of the linear model. It considers not only the individual, but also the individual in context with her environment.

The Medical Model

The earliest recorded diagnosis(Minuchin,1978) of an individual with anorexia nervosa was credited to Dr. Richard Morton in 1689. Morton treated the patient with 'aromatic bags, bitter medicines, and antihysterick waters.' Three months later, the patient died. The physicians treated the organic responses to the syndrome without attempting to focus in on the psychological causes.

Present research is centered on the study of cerebral, pituitary, and hypothalmic factors that may contribute to the illness. The predominate treatment program(Vigersky,1977) is drug therapy with amitriptyline, cyrporheptadine, dilantin, and L-dopa.

The Psychodynamic Model

(Minuchin,1978,pg.14)"Under the influence of the early psychodynamic thinking, the study of anorexia nervosa became the search for a specific psychodynamic of the illness. J.V. Waller, R.M. Kaufman, and F. Deutsch agreed that in anorexia "psychological factors have a certain specific constellation centering around the symbolization of pregnancy fantasies involving the gastrointestinal tract. The alternation of overeating with disgust for food represented to them a shift in the dynamic conflict. In the first instance, the impregnation fantasy was gratified. In the second, the ensuing guilt and anxiety forbad the intake of food."

Falstein(1956) suggested the following, as possible psychodynamic sources of anorexia nervosa: eating may be equated with gratification, impregnation, intercourse, performance, growing, castrating, destroying, engulfing, killing, and cannibalism; while food represented the breast, the genitals, feces, poison, a parent, or a sibling.

Although there were countless accounts by psychodynamic therapists, [Bruch(1973) and Selvini-Palazzoli(1974)] of continual and early conflicts within the family structure, the diagnosis was an individual matter, therefore the prescribed therapy was individual therapy. Bruch, therefore excluded parents from the therapeutic focus, yet their input was recognized. This involvement took the guise of management interviews where parents were advised how to behave with their 'ill' children.

The Behavioural Model

The third and final model of the linear model (Minuchin,1978) is based on operant conditioning. The behavioural therapist suggests that the adolescent's problem involves 'how' the adolescent reacts to external stimuli, and how this pattern of maladaptive behaviour, is the result of previous and current stimuli.

Traditionally, behaviour therapy in exclusion of other forms of therapy, is most effective in controlled consistent environments,e.g. hospitals. However, once the hospital patient has achieved her 'goal' weight, she returns home,i.e. to an unchanged and inconsistent environment.

The Systems Model

The systems model is a circular model. Minuchin believes that the anorectic family has a vested interest in the development and maintenance of the psychosomatic adolescent, while the child's symptoms reinforce and maintains the family's equilibrium. Therefore, anorexia nervosa by Minuchin's interpretation involves not only the adolescent but also the interrelationship of all family members.

Alternate Types of Anorexia

Since 1970, two specific studies have addressed the topic of variants or sub-types of anorexia nervosa. Russell(1979) studied a group of 30 individuals. They displayed a number of common characteristics: an irresistible urge to overeat; followed by self-induced vomiting or purging; laxative misuse and a morbid fear of becoming fat. He defined these individuals as "bulimia nervosa". Unfortunately, Russell concluded that the etiology was unknown; that it was not possible to ascertain whether bulimia nervosa was a result of a prior episode of anorexia nervosa or if it was a distinct syndrome apart, but similiar to anorexia nervosa.

Between 1970 and 1979, Garfinkel studied 207 patients. The study excluded all non-anorexic patients with bulimia, since bulimia could exist in other non-anorexic disorders. He defined bulimia as "an abnormal increase in one's desire to eat, with episodes of excessive ingestion of large quantities of food (e.g., two dozen doughnuts, one gallon of ice cream) usually of high carbohydrates which the patient viewed as ego-alien and beyond her control".(Garfinkel,1982,pg.43) The ritual of the meal would be in exclusion of others, and would be of several hours in duration. Garfinkel seperated his findings into two categories: those patients who exhibited the characteristics of bulimia, and those who did not. The second group he defined as 'restrictive'.

Tables 1 and 2 proyide us with a brief summary of the research conducted by Garfinkel, Moldofsky, and Garner(1980) on 19 of their patients.

'Normal Family' Model v.s. 'Anorectic Family' Model

Within the normal family makeup, two basic characteristics are formed; autonomy and the concept of belonging(Minuchin,1978). This, therefore has great import on the development of the child within the family. As the child matures, he/she develops into an autonomous individual who can rely on the family as a whole for support during times of need. Also, as the family matures, it develops into an autonomous unit which can depend on individual members within the family, or on the family as a whole, for the same support.

The origins of any one family begins with two people. They bring to this association two different, yet complementary lifestyles. They agree to compromise certain differences, and to resolve as many unresolved issues as possible. Once an informal agreement similiar to the preceding one has been initiated, the spousal unit of the family model has been completed.

The second component of the family model, is the sibling unit. For our purposes, we will consider the North American family consisting of approximately 2.2 children. Minuchin feels that the sibling unit represents to each child, their first encounter with a peer group experience.(Minuchin,1978,pg.55)"Within this context, children support, isolate, scapegoat, and teach each other. They develop patterns for negotiating, cooperating, and

competing. They learn how to make friends and allies, how to save face while submitting, how to acquire skills, and how to achieve recognition for skills". The children maintain their individualness, yet learn how to cooperate within this peer unit.

The third, and final component is the parental unit. In many cases the unit may include grandparents, parental children, as well as parents. The function of this unit is to provide nurturance, guidance, and control to the children. Each child learns the necessary patterns of protocol within the family unit. He learns what to expect in support from more powerful and resourceful parents. The manner in which conflict(s) are resolved, are closely monitored by the child and internalized. How parents delegate their authority will determine how the individual conceptualizes their understanding of authority. Will it be rational and consistent? As the child grows and matures, so does the attitude of the parental unit. The unit modifies their concerns of nurturance, guidance, and control, to a level which is complementary to the age-appropriateness of the individual. Relinquishing their control will vary proportionately with the adolescent's need and ability for self-government.

As their children grow up, the parents find themselves in unaccustomed situations. Past cherished family traditions are now of less importance to their children. Children become more secretive of personal experiences. This new sense of autonomy is not only difficult for the parent to adjust to, but equally as difficult for the individual to assume. While the family's 'scale' may be temporarily out of balance, the family is recalibrating its internal structure to accomodate the new and

constructive changes.

One important component of the family model is the sense of boundaries within each distinct unit. Boundaries(Minuchin,1978) by definition, determine the rules of each unit. Therefore, the participants involved in a family conversation, and how they function in the interaction, will be highly subject to the manner in which the boundaries have been defined. For example, if we are considering the parental unit speaking to an older child, "If your sister starts to climb the tree out in the backyard, call me, and I'll come out to stop her."

Inherent in our understanding of boundaries is the notion of clarity within each unit's functioning; and the awareness of the following analogy. "Too many cooks in the kitchen, can spoil the broth." In other words, if a brother and a sister are having a difference of opinion that is specific to their own sibling unit, then it would be wise for the parental unit to only monitor and possibly mediate the conflict.

Before we discuss the personality of the anorectic family, permit me to point out two further concepts of boundaries, i.e. over-involved and under-involved family structures. Typically, when there is any sense of variation in the internal structure of the over-involved family, all members of the family respond to it with excessive speed and intensity. The parent, for example may become overly upset when their child did not eat their dessert. Boundaries are blurred, and differentiation amongst the family units are diffuse.

Second, in an under-involved family, boundaries are overly rigid. Communication is difficult, and the protective functions

of the family are handicapped. Concomitantly, the parents in this family may not respond to a child's delinquent behaviour.

In all families, we have a balanced mix of over-involved and under-involved reactions to situations that occur in everyday life. When extreme reactions become the norm, then we have the 'seed' for the potential anorectic family.

Generally speaking(Minuchin,1978), the anorectic child has grown up in an over-involved family. Typically, the boundaries that seperate the family from the external world are well defined and strong; however within the family, they are loose and weak.(Minuchin,1978,pg.59) "Loyalty and protection take precedence over autonomy and self-realization...Her expectation from a goal-directed activity, such as studying or learning a skill, is therefore not competence, but approval. The reward is not knowledge, but love". The parents become overly obsessed with their daughter's actions. The child, therefore becomes increasingly aware of her every action. This extends to her need to be perfect in all situations. Since she is always striving for perfection and approval. many or all of her responses are hesitant and well-calculated. Not surprisingly, she lacks the ability to be spontaneous. As we have noted earlier from Garfinkel's 1980 study, the anorectic child does not relate well to their peer group. This may be due to their excessive dependence on their parents in combination with their conflicted loyalties to family versus friends. However. the child becomes overly competent in relationships involving adults, for example, teachers.

Hospitalization- A Final Characteristic

Personally I feel, as the sub-heading indicates, the hospitalization of the child indicates the serious state of the illness. Once the adolescent has reached this stage in the development of the illness, the primary goal is to ensure the necessary survival of the adolescent. As I mentioned earlier in the paper, the mortality rates of 10 to 15 percent among this population is common. Therefore. it is of no surprise that in all of the therapeutic models discussed, that the initial emphasis is on the survival of the adolescent.

Each hospital, or psychiatric clinic therapeutically 'handle' the anorectic individual in their own personal way. However, most follow certain guidelines that have been successful with the anorectic child (and family). The major difference that we may encounter between any number of hospital programs, is where the therapeutic model used, consists either of the linear model or of the systems model, and/or a combination of both models.

Tables 3 and 4 summarize two different, yet similiar hospitalization plans. The first(Garfinkel,1982 pgs.233,235), being from Minuchin's Philadelphia Clinic ; and the second, from the Clarke Institute of Psychiatry.

The rationale behind the Philadelphia Clinic's lunch sessions is a simple one. Minuchin believes that the enactment of the issues around the dinner table, will give the Clinic and the family greater insight into the workings of the family and thereby focusing on the true nature of the problem.

Minuchin suggests that the child is only one aspect of the real problem. The true nature of the problem being, the over-involved and diffuse family boundaries, that only encourage further inappropriate familial attitudes and behaviours. Therefore, as Minuchin states, the hospitalization of the child is not the absolute mandate of the treatment program, but rather depends upon the precise medical and psychological issues that are of direct concern to the family. Subsequently, the duration of hospitalization, if required, may be short.

Both Garfinkel and Minuchin admit that the behavioural program is only a part of the treatment that must take place in the hospital. Minuchin continues this point, and stresses the fact that if the behavioural program becomes the total focus of the inpatient's stay, then the entire program perpetuates the power struggle which will predictability result in a 'no-win' situation.

Research-The Unfortunate Flaws

Garfinkel(1982) is concerned with the present state of research methodology with the disorder. He states that all past studies have been retrospective, that is to say, that no reseacher has yet examined a 'large' group of families to determine predictive factors. Inherent in Garfinkel's comment is the basic flaw of many research findings, in that they are based on small sample sizes. What is 'large'? As Garfinkel points out, his study of 207 patients took approximately nine years to be completed, and yet a sample of 207 may have been a critical

factor why Garfinkel could not have achieved more significant data. Also, the years required on the part of the research team to conduct a longitudinal study as complex as Garfinkel suggests, may possibly outlast the desire of the researchers, as well as exhaust vital funds to complete the study.

Minuchin(1978) states that most hospitalized patients stay on an average of two weeks in his Clinic, and this short duration was a function of the therapeutic approach conducted at the Clinic. Garfinkel suggests that this may be the case; however adds that it may also be a function of the age of the inpatient. Therefore, the younger the child, the greater likelihood of a successful prognosis for the family and child. Psychoanalytic theory suggests that the older one gets, the greater likelihood the rigidity of their personality will become. Is it possible that Freud and his followers were the originators of the phrase, "You can't teach an old dog new tricks"? As a teacher working with students who have learning problems, I have noticed a far greater opportunity in remediating students' learning problems at a younger age than at a later stage in their development. Students tend to learn faster since they have less to unlearn.

When we analyze research, we should not only pay close attention to the sample number, but also to the characteristics of the sample. In other words, if the study was a controlled study, who was involved in the control group and who was selected for the experimental? Furthermore, how was the selection done? Was it an objective measure or was it subjective? If it was an objective measure, would it correlate well with the sample chosen for the study? If on the other hand it was subjective, how biased

could the results be?

Garfinkel, honestly points out these flaws as he describes the varied findings of past research. One should add, that Garfinkel is as critical of his and his own colleagues' research as he is with others.

One final comment that I would like to add is that the research is only now becoming aware that anorexia nervosa is not an illness that stops at some fixed age, therefore a "stage" that one grows out of. One grows increasingly aware that anorectic symptoms can emerge at different points of one's life is a result of unresolved earlier conflicts. For example, the adolescent/adult has extreme difficulty with the concept of marriage. Marriage heightens many of the conflicts that the adolescent had when she was overly involved with her immediate family. She must now consider the creation of her own family, one that is separate and unique from her family of origin. She must be able to feel as an autonomous individual, and yet be able to share her decision-making with another.

The Classroom Teacher-Our Dilemma

Finally, let us adress ourselves to what we, as teachers can do for these students. Therefore, the basic question that we, as teachers must contend with, is how to do we effectively deal with the anorectic adolescent in the classroom?

As of yet, research does not absolutely point to any predictive factors that we as teacners could adhere to. All we

can do is to pay close attention to the personality traits of these individuals, who appear to be 'well-behaved'; perfectionistic; manipulative; and who are 'high achievers'; and therefore, be sensitized to their difficulties while they attend our schools. Sooner or later, they will return to the classroom from either a clinic or hospital and we the teachers, must address their excessive need to consume information. Generally, they will be unable to let us know what are reasonable limits of work that they can handle. Their motto is " The completion of the task, generates the approval of an adult. Knowledge is secondary".

Although the etiology of anorexia nervosa may be unknown, what is clear, is the predicament that the adolescent is in. The more she increases in weight, the lower self-image she has. She senses that her last domain of control is being attacked, therefore she resorts to extreme measures. The teacher must be supportive of her difficulties, yet be aware not to enter into a struggle for control. This is her revolution, her statement that she desires to be an independent and autonomous individual. This is the true nature of the 'illness'. One cannot overly emphasize the fact that the anorectic adolescent is exhibiting similiar behaviours that their peers are demonstrating, however their reactions are far more acute than their classroom colleagues.

Their relationships with fellow peers are superficial or non-existent(Table 1 and 2). The relationship(s) that they may have with their teachers could result into an extension of their relationship with their parents, or a relationship that encourages them to develop as autonomous and responsible

individuals. One approach that the teacher can use to benefit her student's sense of autonomy, as well as, on her relationships with her classmates, is to provide the class with opportunities for group activities. Implementing this strategy, the teacher could not only monitor the anorectic's involvement in group activities, but also could encourage greater participation in activities that involve the development of the 'art of negotiation, cooperation, and competition' in socially acceptable ways.

The teacher must also be aware that the anorectic adolescent has acquired over the years highly refined techniques of manipulation through the monitoring of her family. She is also skilled in 'playing one authority figure against the other'. What she may not get from one, she will attempt to get from another. This will include the ever-popular game "teacher versus teacher". These are behaviours that should not be taken personally. If we do, it would make us less effective as teachers.

Teachers working with students who experience emotional difficulties tend to have the following situation occur. Often I have been advised that a specific student that I will be teaching tends to react more positively with a male(female) teacher than a female(male) teacher. The probable answer to this reaction is due to their positive or negative relationship that they had with either one of their parents. Therefore, the student could transfer personality traits that were existent with their parents onto the teacher. Moreover, the student may classify a teacher only as a good or as a bad person; i.e. interpreting the teacher only as a two dimensional object. In order to intervene and

clarify the student's unrealistic perceptions of her teachers, we must collectively be aware of the conflicts that will be raised by these "idealized" teachers. Comprehending that the student has recreated within the teaching staff, through her use of idealized "good and bad" labels, the constant turmoil that went on between her and her parents; will we as professionals, act in an appropriate and objective manner.

Objectivity is not the simplest of tasks encountered by any teacher. The anorectic adolescent will attempt to drain the teacher's energies to the point where the teacher may emotionally "react", as opposed to objectively "act" to a classroom situation. At this point, the teacher may react to a specific behaviour in such a way, that he/she may feel guilty and regret how the whole situation ocurred. For example, a former professor of mine told his class of graduate students, that he had a noticed when he taught in the elementary schools, he gave preferential treatment to a specific group of individuals. They were blond, blue-eyed little boys and girls. For a short period of time, he "judged the book by its cover". I should add he and his father were also blond and blue-eyed. Once he realized that he had this bias, he decided to create a system that would monitor sensitive issues that were specific to his own personality, which could interfere with the appropriate management of his students. He called his system, the "third eye". This third eye would hover over his classroom and monitor how he and his students related. When he began to loose his objectivity in any given situation, the "eye" would make him aware of it, and he would act accordingly.

My professor's former bias or personality trait was only one of many qualities that made him what he was. He admired people who were independent, trustworthy, and who had the instinct to survive. Also, he was empathetic to those people who demonstrated a potential to achieve a greater sense of independence, the capacity to trust and the struggle to survive. These characteristics were developed by watching his father and mother struggle to provide their family with the best education and family life, that could possibly be attained, given a very difficult life. Unfortunately, there would be times when he would become impatient with those students who would rather give up the challenge than fight to suceed. Their intense sense of hopelessness and helplessness were so great, that it brought out the "knight in shining armour that could slay their dragon, that was raging deep inside". This intense need to rescue these individuals, only ended up in disaster. He became angry at their inabilty to internalize his thoughts, and became guilty because of his own failure to be a good role model. His students were never satiated by his heroic efforts, because his efforts were too close to his own personal makeup.

The "third eye" in subsequent situations would ask him "Why are you reacting in this situation, the way you are?" Are you possibly over-reacting to this student's classroom behaviour? This simple, yet difficult strategy to master, has provided me with the knowledge and strength to attempt to teach emotionally distressed students over the pasts 4 years in a more comprehensive and nurturant way.

Pedagogically, we can include reading materials in our

English curriculum that would enlighten the high school population of the internal conflicts that the anorectic family encounters. High school students have become aware of Autism through the use of easy-reading materials, such as Son Rise, as described by the personal experiences encountered by the Kaufman Family. The pocketbook, titled "The Golden Cage" by Dr. Hilda Bruche is widely used in treatment centres as an early step in the explanation of the anorectic disorder.

In conclusion, the teacher's task with the anorectic adolescent is to provide a classroom environment that is consistent and clear in structure; secondly, to support the student's individual needs and realistic abilities, while being aware of the disproportionate parental pressures and concerns of their child's academic life; and thirdly to act on student behaviours in the most objective and appropriate manner that we possibly can.

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TABLE 1

Bulimic patients (97 patients)

-upper and middle class overrepresentation in comparison with general population
-bulimics tended to be ill longer
-bulimic patients generally weighed more
-20% were obese premorbidly(defined as greater than 115% of average for age and height)
-relied heavily on avoiding meals, whenever possible, and when this was not possible, on selecting low carbohydrate foods.
-hid foods frequently
-vigorous compulsive exercising aimed at burning calories
-frequently vomited and misused laxatives
-diuretic misuse was uncommon
-21% of bulimics misused street drugs
-alcohol use and stealing occurred significantly more frequently in bulimics
-suicide attempts and deliberate acts os self-inflicted injury without suicide intent were more common in bulimics, however the latter was not statistically significant
-20% of bulimics had made prior suicide attempts
-less commonly isolated and more more frequently engaged in transient and nonsatisfying relationships
-more sexually active and more likely to use oral contraceptives
-could not describe their sexual experiences as pleasant
-overrepresentation of anorexia nervosa in siblings(6%) and multiple births(4.2%)
-49% of mothers of bulimic patients were obese

TABLE 2

Restrictive patients (96 patients)

-upper and middle class overrepresentation in comparison with general population

-obesity was rare (only 8%)

-relied heavily on avoiding meals, whenever possible, and when this was not possible, on selecting low carbohydrate foods.

-hid foods frequently

-vigorous compulsive exercising aimed at burning calories were common

-11% of restricters misused street drugs

-8% of restricters had made prior suicide attempts

-relatively isolated and formed few friendships

-less than 20% of restricters were involved in social relationships and found them satisfying

-overrepresentation of anorexia nervosa in siblings(6%) and multiple births(4.2%)

-32% of mothers of restricting patients were obese

TABLE 3

Philadelphia Clinic-hospitalization for approximately 2 weeks

-hospitalization for investigation to rule out organic factors
-informal lunches to assess the patient's negativism
-initiation of operant procedures to achieve weight gain
-(Minuchin,1978) family therapy lunch sessions; usually two hours in duration
-weekly outpatient family therapy

TABLE 4

Clarke Institute of Psychiatry-hospitalization for approximately 8-12 weeks

-controlled weight gain in a setting of emotional support
-information feedback and dietary reeducation
-a graduated level of activity, often beginning with bedrest
-emphasis that weight gain is necessary but only one part of treatment
-occupational and group therapies
-a relationship type of individual psychotherapy
-family therapy

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